62.

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Ontario's Maximum Security Hospital at Penetanguishene:

Past, Present, and Future

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The Early Years

The Oak Ridge Division of the Penetanguishene Mental Health Centre, as it is now known, opened in 1933 as the "Criminal Insane Building." The institution has always been under the jurisdiction of the provincial Ministry of Health, although throughout its history both correctional and mental health institutions have referred patients. The first 100 patients (who then, as now, were all male) came from a reformatory that was overcrowded with regular inmates, and it was decided that a new place was needed for the province's "criminally insane." Most of the early patients had already been incarcerated for long periods of time before they arrived at Oak Ridge. In fact, a biography of an early patient named Valentine Shortis reveals that he had already spent 40 years in prison before he came to Oak Ridge (Friedland, 1986).

By late 1933, nearly all the 152 original beds were full. Increasing pressure for more bedspace led to the construction in 1957 of four new wards fashioned almost exactly after the first four that, in turn, had been modeled on earlier maximum security prison designs. The new beds were opened and filled over the period 1958 to 1962, and until the early 1980s Oak Ridge housed approximately 300 men.

The patients in Oak Ridge have always been a heterogeneous group. When the building opened, nearly half of the patients had been found either not guilty by reason of insanity or unfit to stand trial. Most of the others had been found to be mentally ill while serving prison sentences and had thus been labeled "criminally insane." Some of these were serving life sentences, but many had sentences that had expired long before their arrival at Oak Ridge. These men were held under legislation permitting indefinite detention for mentally disordered offenders. Over half of the patients had committed a homicide

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The opinions expressed in this manuscript are those of the authors and do not necessarily represent those of other staff or officials of the institution or the Government of Ontario.

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63.

or attempted homicide. On the other hand, a small portion had been charged with no criminal offense, but were sent to Oak Ridge because they were considered to be too dangerous to be managed in any other mental health facility. Records reveal that in late 1933, there were 140 patients and a total of 27 security and clinical staff (who worked an average of 73.5 hours per week and lived on the wards!). From the beginning, however, the majority of the front line staff have been "attendants." In the beginning, these men had no specified prior training for their duties.

Although the goal of institutionalization in the 1930s and 1940s was primarily safe custody with little emphasis on treatment or rehabilitation, the lives of many patients were busy and not unpleasant compared with today's standards in similar facilities. Written records of life in Oak Ridge during its first 2 decades are sparse. However, we do know that many patients were assigned to work crews outside of the building, and many others worked in the kitchen or on the wards. Patients attended occupational therapy classes and religious services. Many patients attended school where they upgraded their education, and some obtained high school diplomas. Several hours a day were devoted to sports events, and there were frequent tournaments in such events as baseball and bridge. Movies were shown occasionally, and patients received regular rations of tobacco. On the other hand, there were also many patients in Oak Ridge who spent virtually all of their time locked in their rooms. The average length of stay for the patients who came in 1933 was 10 years, and almost half of the first 100 patients died in the institution.

The Building

The original building that opened in 1933 was a U-shaped red brick structure in which each of the 2 arms of the U contained an upper and lower 38-room ward. Each ward comprised a long central corridor with single bedrooms on either side and a large "sunroom" at the end. As mentioned above, by 1962, the original structure was duplicated (adding four more wards) and the two U's were joined by a long corridor. Each patient's room was a concrete cell with a solid or barred iron door, iron bars over every window and there was virtually no program or office space. However, several workshops and recreation areas were developed in the basement, and office areas and a multipurpose canteen/visiting centre were added in the 1970s and 1980s. Small exercise yards have existed from the beginning between the arms of the U's and, in the early 1980s, a much larger fenced yard was added. Reductions in the size of the patient population have permitted the conversion of many patient rooms to staff offices and program areas (kitchens, group therapy rooms, etc.). Finally, in 1991, a gymnasium/swimming pool complex was added to the building. Despite many important improvements to the building, Oak Ridge is not considered to be physically suitable for the treatment of forensic psychiatric patients. Despite its grim exterior, however, the building has advantages not found in many hospitals or prisons. Its security record is very good: it has been 20 years since the last successful escape. Also, the fact

that each patient has his own room has unquestionably made Oak Ridge a safer place for patients.

The Introduction of Treatment Programs at Oak Ridge

Until the mid 1960s, there was very little in the way of psychotherapy or other psychological treatment for Oak Ridge patients. However, the medical superintendent at that time (Dr. Barry Boyd) hired a psychiatrist (Dr. Elliot Barker) who was eager to develop a therapeutic community for mentally disordered offenders. The program implemented on the four wards comprising the Social Therapy Unit (STU) drew world-wide attention for its novel approach to treatment, especially for psychopaths, and considerable numbers of psychopaths were recruited into the program by hospital clinicians either supporting a court verdict of not guilty by reason of insanity, or accepting men from prison into the program while they served their sentences. The program has been described in detail elsewhere (see 8,9,20,31,32, and 53 in the Appendix). Briefly, the program was primarily peer-operated and patients were involved in intensive group therapy for up to 80 hours per week. Patients participated in regular daily sessions with one or two other patients, and sat on committees that monitored and structured all aspects of their lives in the institution. Patients who performed well in the program and who showed organizational talent were appointed to program leadership roles, led therapy groups, and sat on security and administrative committees. Patients participated in decisions about one another's release and transfers.

In addition to the therapeutic community, there were other important features of the program. Patients had very little contact with professional staff, very little time was spent in organized recreational programs, and, except on one ward, patients were not allowed to engage in academic upgrading or vocational training. On one of the four wards, patients worked in contract workshops, the kitchen, or on cleaning groups. Although some vocational training was provided, such work was regarded primarily as a "rest" from therapy. There were no programs specifically aimed at teaching social skills or social problem-solving, or life skills training. Tight internal and external security in the therapeutic community were maintained by patients in cooperation with psychiatric attendants. Patients in the therapeutic community had very little opportunity for diversion. The program imposed tight limits on viewing television, reading material, and even on social interaction between patients.

A person's willingness to participate in treatment was not a major determinant of admission to or discharge from the therapeutic community. For example, an individual found not guilty by reason of insanity in the province during the study period might be assigned to the program even if he did not wish to be. Once in the program, patients who refused to engage in detailed discussion of their offenses, backgrounds, and feelings could be sent to a disciplinary subprogram where they spent time discussing their motivation, attitudes, and participation until they complied with program requirements. Very few privileges were available while they were in this subprogram. It should be noted that although there are several aspects of the program that would be seen to

violate patients' rights by today's standards, the program was very favorably viewed on both ethical and clinical grounds by other professionals at the time. In fact, the chairman of a parliamentary subcommittee in 1977 said of the techniques used in the program: "[that they] are the most fruitful anywhere in the universe at the present time, based on the knowledge we have gathered" (Government of Canada, 1977, p. 45). In a report for the parliamentary committee (Butler, Long, & Rowsell, 1977), the program was reported to have "a very low recidivism rate" (p. 3).

Despite the program's very favorable reputation, the program began a slow death in 1978 when local administration and bureaucrats at the Ministry of Health head office in Toronto gave in to demands of the attendants (who were in conflict with professional staff over control of the program), and permanently banished the unit's entire clinical team from the building. Although it is possible that the political dispute could have been successfully resolved by mediation, no such intervention was made. Instead, the banishment left the institution's remaining professional staff with the belief that administration would support the attendants and not them in times of conflict. Even without this crisis, it is likely that the program would have eventually met its demise due to increasingly stringent criteria for consent to treatment in the provincial mental health legislation, and by increasing pressure from advocacy groups who attacked some of the program's more sensational aspects, such as the use of LSD. Moreover, a retrospective evaluation of the program revealed that although nonpsychopaths fared better upon release than their counterparts who went to prison, psychopaths treated in the program actually had higher rates of violent recidivism than their prison counterparts (see 101 and 105 in the Appendix).

In the early 1970s, different programs were implemented on the unit comprising the remaining four wards of Oak Ridge. The programs and evaluations of them are described in detail elsewhere (see 18,53,89,93, and 104 in the Appendix), but a brief description is given here. The patients on the Activity Treatment Unit (ATU), as it was called, were those considered to be unsuitable for a therapeutic community because they had a history of assaultiveness in institutions, or because they were of subaverage intelligence, were thought to be too old to fit in, were too psychotic, or were not sufficiently fluent in English to participate. As a group, the patients on this unit demonstrated behavior problems ranging from assaultiveness within other institutions to criminal behaviors of varying degrees of severity. The unit was best equipped to treat patients who frequently exhibited problem behaviors within a hospital setting.

The ward programs were based on an attempt to blend security considerations and behavior modification principles. Patients earned privileges for exhibiting carefully specified desirable behaviors and lost privileges for undesirable behaviors. The programs and ward structure were designed in such a way that, as the patients developed more stable and acceptable patterns of behavior, they moved from more secure, minimum-privilege wards to less secure, maximum-privilege wards. Transfer to the next level in the progression occurred only when the patients had met well defined criteria for changes in status.

The programs on the two more secure wards were primarily aimed at reducing assaultive behavior, teaching basic hygienic skills and simple work habits, and improving the patients' mood and cooperation. One ward functioned as the admitting and initial assessment area for the unit, whereas the other ward provided carefully structured programs for long-term patients. Special groups to teach social skills, assertiveness, heterosocial skills, or anger control were run for certain patients.

With a transfer to one of the two less secure wards, patients progressed to more complex activities where the rewards were less immediate and direct. During the day, patients typically worked in any of a number of off-ward areas at jobs ranging from packaging objects, to hammering wooden skids, to reupholstering or refinishing furniture. The emphasis in most of the work areas was on learning social behaviors and good work habits rather than particular skills. On one of the less secure wards, the program was similar to that on the more secure wards, but placed greater emphasis on increased social activity and shaping the patients' ability to monitor and control their own behavior. The other ward provided a relaxation of intensive ward programming and a simulation of the kind of ward environment the patients would likely encounter on leaving Oak Ridge, thereby allowing for an assessment of the patients' readiness for discharge.

While the ward programs were the focal point of treatment, the various off-ward recreational, educational, and vocational activities played an important role as well. These off-ward areas had their own treatment programs and assessment procedures which, in turn, were closely allied with the programs on the wards. In addition, pharmacological treatment was an important part of the overall program.

Although there was evidence that patients learned specific skills in the programs on this unit, there was little evidence that performance in the program or improvement in the program were related to reduced criminal recidivism upon release (see 93 in the Appendix).

Research at Oak Ridge

Although not formally established until 1976, the research department arose out of a program of research that began in 1971. This early program of research was encouraged by hospital officials because there had been neither followup studies of mentally disordered offenders in Ontario nor any program evaluations. In addition, there was no specialized assessment or treatment for the many sex offenders, especially child molesters, within Oak Ridge. Child molesters presented special problems because no one had an idea about what treatment to offer them and there was also great uncertainty about how to arrive at a decision to release or retain them. Related to these concerns was the conviction, based partly on the results of university-based research that had already been conducted at Oak Ridge, that research originating from universities would be unlikely to address the needs of the institution. As a result, a research committee was developed that reviewed research proposals, whether external or internal in origin, in order to exercise quality control, as well as to ensure that research furthered the objectives of the institution.

In 1971, the very low staffing levels required all Oak Ridge professional staff to provide full-time clinical service and a research department was out of the question. Research efforts at that time were either conducted outside of working hours, or were part of ongoing treatment programs. By 1973, nevertheless, there was a research effort that focused on prediction of outcome among released patients, evaluation of behavioral programs, and the assessment and treatment of child molesters. Although these were only part-time efforts, funds were made available from the province to construct operant and sexual behavior laboratories. Efforts to obtain extramural funding that began in 1972 have resulted in the department receiving over $1,000,000 in grants to date. Grant staff were seconded part-time from various research grants to help maintain what became known as the sex offender program; in fact, the program would not have existed without them. The use of extramural funds to support research and also to facilitate treatment that began in 1973, has continued in one form or another to the present.

The research department under the leadership of Dr. Vernon Quinsey was created in January of 1976, with two full-time staff. This development was made possible by the expanding numbers of treatment staff at Oak Ridge. With the creation of the research department, greater emphasis was placed on gathering data that would facilitate administrative actions and policy formation. The department grew from two in 1976 to, at present, seven full-time hospital-funded positions. In addition, there are usually one or two persons in the department working on externally funded grants or contracts. The research focus expanded to include sexual assaulters of women, arsonists, institutional violence, men found not guilty by reason of insanity, and psychopaths. A list of publications pertaining to Oak Ridge (most of which, since 1976, have been written by members of the research department) may be found in the Appendix.

Reorganizing Oak Ridge

After the political battle on the STU in 1978, the unit was headed by a succession of physicians without much awareness of, or personal commitment to, the original clinical or philosophical principles. The tradition of having few professional staff remained however, and the unit was in fact run by attendants and patient teachers. Clinically, the STU was moribund. At the same time, external political forces, including the creation in 1983 of psychiatric patients' advocates throughout the province's psychiatric hospital system, created considerable pressure on the hospital's administration. The suicide of a patient in 1982 resulted in adverse publicity for the institution. Combined with the increasing use of litigation by patients, an increasing expectation from review boards that physicians defend their disposition decisions, as well as increasing protests from lobby groups such as the Scientologists all meant that what went on inside Oak Ridge came under increasing scrutiny.

In the face of these pressures, the hospital's administration decided to reform Oak Ridge by reorganizing the two units into four two-ward units. On four wards, the restructuring merely meant continuing established practice under a new name. Whereas in the old structure each unit granted its own admissions,

in the new structure all admissions came to a two-ward assessment and treatment unit that was very well staffed and that attempted to amalgamate some aspects of the old STU program with more traditional methods. However, the most dramatic innovation was that the behavioral programs on the old four-ward ATU were recast into a new two-ward Behavior Therapy Unit (BTU) under the direction of a psychologist. The new organization for Oak Ridge went into effect in June of 1983.

The Hucker Report

Some of the unit directors were strong and capable clinicians assisted by competent and ambitious multidisciplinary teams. Despite its outmoded and prison-like physical appearance, by late 1983 the hospital's administration was convinced that the continuing political pressure aimed at Oak Ridge was primarily a reflection of conditions that no longer existed. In what was possibly an attempt to silence the critics and get money for a new building, the hospital's administration asked the branch head office for an in-depth review of all facets of clinical and administrative operations in Oak Ridge. A "blue ribbon" panel of experts, led by Dr. Stephen Hucker, a forensic psychiatrist from Toronto's Clarke Institute of Psychiatry, was convened. The six member committee (a lawyer, two psychiatrists, a psychologist, a nurse, and a layperson) began its investigations in early 1984 and issued its final report in December of 1985 (Hucker et al., 1985).

The Hucker Report, as it came to be known, was much more critical of the institution than most staff had anticipated. The report listed 89 separate recommendations for specific changes. The final recommendation was that the building should be closed, and one new, smaller 100-bed unit should be built in Penetanguishene and another near a large urban center. Within a year, the two most senior administrators had left. In addition, two physician unit directors were replaced by nonmedical professionals. By 1987, all of the four Oak Ridge Unit Directors were nonphysicians (one occupational therapist, one registered nurse, and two psychologists). The Hucker Report was also critical of the generally low level of professional training of Oak Ridge staff, the low staff to patient ratio, the lack of clear clinical thrust on many wards, and the dismal physical structure of the building. As a result, more attendants were sent to nursing school, an R.N. certificate became a requirement for the jobs of ward supervisor and more senior nursing positions, new positions for non-nursing clinical staff were created, more female nursing staff were hired and renovation of the wards was begun. Whereas Oak Ridge had previously had no administrative structure separate from that of the regional psychiatric hospital on the same grounds, the Hucker Report resulted in Oak Ridge being granted more autonomy by the appointment of its own associate administrator and clinical director. In order to increase the number of forensic psychiatrists, a team of consulting psychiatrists from the Clarke Institute of Psychiatry in Toronto began to provide coverage by each working at Oak Ridge one day a week. Although not all of the Hucker recommendations have been implemented, the report had a profound impact on the institution—an impact that is still being felt. One important result was that the clinical leaders sought a

way to refocus and revive the institution's clinical efforts. In so doing, they adopted a novel empirical approach.

An Empirical Approach to Reorganization

Throughout 1986 and 1987, the Oak Ridge unit directors sought to reshape the institution in order to better serve the existing and anticipated patient population. Consequently, the present authors were asked to conduct a detailed survey of the clinical needs of the entire patient population. The methods employed in this survey have been well described elsewhere (see 84 and 96 in the Appendix), and only a summary will be presented here.

The study employed a 70-item checklist that was completed by clinicians for each of Oak Ridge's 189 patients. The items on the checklist were of two main types: (a) problems exhibited in the institution, and (b) problems exhibited previously in the community. The problems subsumed a wide variety of symptoms (e.g., psychotic speech, depression); deficits (e.g., poor reading skills, social withdrawal); aggression (e.g., assaults, threats); and others (e.g., alcohol abuse, unpopularity).

The first important result of this project was the discovery that there were some problems whose frequency was higher than anyone had suspected. This led to the realization that many Oak Ridge patients had important clinical problems that may have contributed to their offenses (e.g., alcohol or drug abuse), and for which they had never received any treatment or help. The second part of the research employed a variety of rational and statistical means to simplify the problem data. The results of this process showed that many patients exhibited serious and important problems that were not traditional psychiatric symptoms, and that could best be addressed by skill-teaching programs of various kinds. The third phase of this empirical approach to planning was the use of other statistical techniques (cluster analyses) applied to problem scale scores to simplify the patient population into clinically homogeneous subgroups. The final phase of this empirical effort was to use the data to motivate recommendations for the clinical and administrative organization of Oak Ridge.

In 1988, some of the recommendations were adopted and the clinical focus of some Oak Ridge units was altered as a result. For example, one of the BTU wards was devoted to patients who experienced serious positive symptoms of schizophrenia and the ward token economy was redesigned to reflect the clinical needs of this patient cluster. In 1988, large scale transfers of patients were effected in order to implement some of our recommendations.

Oak Ridge in 1991

The Patient Population

On January 1, 1991, there were 122 patients in Oak Ridge. The number of patients has been declining continuously since the mid-1980s. The reduction in beds occurred partly because the province began to create medium-secure units in 1976, which permitted the transfer of many well-behaved Oak Ridge pa-

tients. Another influence was the political pressure by consumer advocates to reduce the number of civilly committed patients in the facility.

A description of the current cross-sectional patient population is given in Table 1, and a description of the patients discharged in 1990 is given in Table 2. Data on patients admitted are not presented because they were very similar to the discharge population, with the exception that there were no voluntary admissions. The five voluntary patients discharged were patients who were admitted in one of the other categories; interestingly, their average length of stay of almost 7 years was the longest of any group. As may be seen from the large standard deviations for length of stay, some men get out very soon while others stay for a very long time. In fact, the record for the longest continuous stay in Oak Ridge was set by a recently discharged patient, who left as a voluntary patient when the warrant holding him as unfit to stand trial was lifted after nearly 40 years.

Treatment Programs

Although the clinical character of Oak Ridge changed considerably throughout the 1980s, the recommendations for clinical changes, based on the problem survey described above, were only partially adopted. For example, it had been proposed that a ward be set aside for time-limited treatment of candidates from correctional institutions, but due largely to wrangling over fiscal arrangements, this never materialized. In addition, rather than having treatment resources centralized so that specialized programs could be offered to patients regardless of unit, it was instead decided to strengthen the autonomy of unit teams by decentralizing services so that most clinical staff were assigned to a single unit only.

There were two main reasons for these trends. First, correctional institutions, having met with years of frustration in attempting to place mentally disordered offenders in psychiatric hospitals, developed their own treatment centers. Secondly, the patient rights movement (which had begun in the late 1970s) continued to grow, and partly as a result, the province's laws pertaining to consent to treatment were revised in 1978 and again in 1987. Many Oak Ridge patients (especially those who would have occupied the ward for personality disorders) availed themselves of their right to be protected from the imposition of unwanted treatment, and declined to participate in many vocational activities and other therapy programs. This trend was further exacerbated by review board decisions that permitted several patients who had refused all treatment to leave Oak Ridge for less secure settings, thus reinforcing a notion that participation in treatment had little to do with release. Furthermore, the reduction in the patient population meant that many of those most amenable to treatment left, and those who remained presented the most difficult treatment challenges. The patient rights movement was also largely responsible for decisions to stop employing patient labor in cleaning, food preparation, and groundskeeping; and for providing patients with a monthly noncontingent "comfort allowance." Thus, the vocational programs considerably altered their focus and now offer much more intensive and individualized services. Very few patients now have paid employment, many spend large parts of the day

TABLE 1
Description of Oak Ridge Cross-Sectional Population on January 1, 1991

	Admission Documentation				
	Assessment[a]	NGRI[b]	Unfit[c]	Inv[d]	Total
Number of patients	4	77	13	28	122
Age – (years)	28.80	35.93	32.16	37.72	35.71
Referral source (%)					
Corrections[e]	—	1	—	11	3
Jail	—	6	—	—	4
Court	100	53	92	36	55
Retardation facility	—	—	—	7	2
Psychiatric hospital	—	37	—	43	34
Other/unknown	—	4	7	3	2
Primary diagnosis[f] (%)					
Schizophrenia	50	55	—	75	61
Other psychosis	—	4	77	—	4
Personality disorder	—	32	15	11	23
Retardation	—	3	—	11	4
Other	50	6	8	4	7
Previous admissions to psychiatric hospital[g]	1.75	5.08	8.92	6.71	5.75
Previous admissions to Oak Ridge	1.50	1.75	0.85	1.14	1.51
Most serious offense[h] (%)					
Homicide	—	47	—	4	30
Attempt murder	—	19	15	—	14
Sex offense[i]	—	16	15	11	14
Assualt	50	10	38	32	20
Abduction	—	1	—	—	1
Robbery	—	3	15	7	5
Weapons	25	1	15	—	3
Arson[j]	—	1	—	7	2
Property	25	—	—	4	2
Other	—	—	—	—	—
None/unknown	—	1	2	36	9
Previous admissions to corrections	1.50	1.26	1.85	.82	1.23
Occupation (%)					
None	50	29	62	46	37
Unskilled/semiskilled	50	44	31	21	38
Skilled	—	3	8	4	3
Clerical, sales	—	—	—	—	1
Managerial, professional	—	3	—	7	3
Other/unknown	—	19	—	21	17
Education (years)	10.75	9.41	9.67	9.71	9.54
Marital status (% never married)	75	82	92	96	86
Length of stay (months)					
Mean	2.48	55.93	15.36	67.06	52.41
Standard deviation	2.41	48.56	20.40	81.08	57.24

Note. Percents total to 100 within a column.
[a]Patients on a court-ordered 30 or 60 day assessment.
[b]Not guilty by reason of insanity.
[c]Unfit to stand trial.
[d]Civilly committed.
[e]Includes provincial and federal correctional facilities but not local jails.
[f]Diagnosis given by hospital physician or psychiatrist.
[g]Admissions to hospitals other than Oak Ridge.
[h]Most serious offense leading to admission to Oak Ridge.
[i]Sex offenses that did not result in charges of murder or attempt.
[j]Arson offenses that did not result in charges of murder or attempt.

TABLE 2
Description of Oak Ridge Discharge Population for 1990

	Discharge Documentation					
	Assessment[a]	NGRI[b]	Unfit[c]	Inv[d]	Vol[e]	Total
Number of patients	49	20	16	10	5	100
Age (years)	34.30	38.47	34.99	33.91	48.20	35.90
Diagnosis[a] (%)						
Schizophrenia	39	63	75	40	75	51
Other psychosis	8	11	13	10	—	9
Personality disorder	43	26	6	40	—	32
Retardation	—	—	—	10	—	1
Substance abuse	2	—	—	—	25	2
Other	8	—	6	—	5	5
Previous admissions psychiatric hospitals[a]	4.53	6.25	7.93	7.00	8.60	5.86
Previous admissions to Oak Ridge	.84	1.65	.56	1.10	1.20	1.00
Most serious offense[a]						
Homicide	10	45	—	—	20	15
Attempt murder	10	25	6	—	—	11
Sex offense[a]	22	—	13	—	—	13
Assault	27	10	50	30	20	27
Abduction	—	5	—	—	—	1
Robbery	2	10	—	10	—	3
Weapons	6	5	19	30	20	11
Arson[a]	6	—	6	10	—	5
Property	14	—	—	—	—	7
Other	—	—	6	—	20	2
None	2	—	—	20	20	5
Previous admissions to corrections	2.24	1.05	2.44	3.50	2.60	2.18
Occupation (%)						
None	49	25	38	60	40	43
Unskilled/semiskilled	37	50	56	20	60	42
Skilled	6	—	—	—	—	4
Clerical, sales	2	—	—	—	—	1
Managerial	—	5	—	—	—	1
Other/unknown	6	20	6	20	—	9
Education (years)	9.43	9.35	10.00	9.13	6.60	9.33
Marital status (% never married)	53	70	69	100	80	65
Discharged to (%)						
Court	98	5	94	30	20	69
Psychiatric hospital	2	95	6	40	40	26
Self	—	—	—	10	—	1
Other	—	—	—	20	40	3
Length of stay (months)						
Mean	2.06	56.90	9.29	20.43	82.31	20.03
Standard deviation	1.56	38.61	7.33	35.68	120.09	40.53

Note. Percents total to 100 within a column.
[a]Patients on a court-ordered 30 or 60 day assessment.
[b]Not guilty by reason of insanity.
[c]Unfit to stand trial.
[d]Civilly committed.
[e]Voluntary patients.

without structured activity, and a few decline all programmed diversionary or therapeutic activities.

It is somewhat ironic that at the same time as fewer patients wish to partake in treatment, the continued reduction in the size of the patient population, and the growing size and professionalization of the clinical staff, have meant that Oak Ridge patients now have a wider range of available therapeutic and educational opportunities than ever before. In contrast to 1933, in mid-1991, there were 293 clinical staff for 119 patients. The current clinical staff to patient ratio of 2.5 is over 13 times what it was in 1933! Some of the treatment opportunities on each of the four units are summarized in the brief program descriptions that follow:

Behavior Therapy Unit (BTU). The two wards on this unit house a total of 38 patients, most of whom are actively psychotic. The unit continues to operate simple token economy programs. As described elsewhere (see 108 in the Appendix), the programs have come to rely heavily on the use of response cost, and have found it increasingly difficult to target specific, observable, and countable behaviors. The clinical staff of the BTU conduct some individual behavior modification programs and also run several other therapeutic activities, especially life skills training, social skills training, and therapeutic recreation programs. Despite its name, reliance on behavior modification as an exclusive or primary model of treatment has disappeared, and the current treatment philosophy might be better described as eclectic.

Social Management Unit. This unit houses a total of 41 patients on two wards. Although the majority of patients on both wards are diagnosed as psychotic, they are generally high functioning and nonassaultive. A significant minority of the patients are personality disordered. Several patients (both psychotic and personality disordered) refuse all treatment. This unit's management team adopted a simple point-based level system to determine patient access to privileges and to make dynamic security decisions. Recently, current and former patients on this unit have presented Oak Ridge administration with an interesting legal problem. Patients (many of the same individuals who decline the therapeutic opportunities described above) have sued the institution and the government, arguing that they have been forced to live in inhumane conditions and have been denied access to appropriate psychiatric treatment. The relief sought by the plaintiffs, of course, is to be sent to another (less secure) institution with more pleasant surroundings, where they claim there will be more treatment.

On the other hand, some of these same patients have also launched a lawsuit arguing that they have received psychiatric treatment (in the form of behavior modification via the ward privilege level systems) against their will. The relief sought, of course, is immediate noncontingent access to all privileges within Oak Ridge or transfer to a more appropriate institution. Despite the morale problems and distraction from real clinical issues caused by the litigiousness of some psychopathic patients, the Social Management Unit staff offers a wide variety of therapeutic activities including social skills training, life skills training, and general and therapeutic recreation.

Rehabilitation Unit. The Rehabilitation Unit currently comprises a single ward housing 21 patients, almost all of whom are personality disordered and for whom relaxations in perimeter security are unwarranted. Many of the patients on this unit decline to participate in treatment because to do so would imply that they agreed that they had important clinical problems in the first place. However, clinical staff continue to offer considerable individual counseling and psychotherapy, as well as group programs in life skills and vocational training.

Forensic Assessment Unit. All newly admitted patients reside on the single ward forensic assessment unit which houses 20 patients. One purpose of a patient's stay on this unit is to evaluate his suitability for other Oak Ridge units. For this purpose, the areas of most importance are assaultiveness and other problems of institutional management, positive schizophrenic symptoms, and general level of functioning.

A small number of patients, having been charged with (or more rarely, convicted of) a serious offense, are still remanded to the Forensic Assessment Unit. The purpose of the assessment is usually to determine the accused person's fitness for trial and his suitability for a defense of insanity. In cases where the patient has already been convicted, the major assessment issues pertain to whether he meets the criteria associated with an application to have him declared a dangerous offender (and thereby receive an indefinite sentence).

Conclusions

Several interesting themes emerge from our historical look at Oak Ridge. In many ways, Oak Ridge is simply a microcosm of the whole mental health system and it is clear that these themes characterize much of the recent history of efforts to assess, treat, and make decisions about mentally disordered offenders.

Paucity of Forensic Clinicians

Throughout Oak Ridge's history, it has been asserted that its problems (in terms of providing treatment for its patients) are due to its lack of forensic psychiatrists or other forensically trained clinicians. It is further asserted that this shortage is due to the lack of realistic opportunities for private practice in a small community; distance from a university; or scarcity of teaching, research or other academic activities. It is interesting, however, to note that the premise of this syllogism is probably false. That is, over the years, there has been at least as much treatment and research going on in Oak Ridge as there has been in any other psychiatric institution in the province. For example, no therapy program could have been more intensive than was the Social Therapy Unit of the 1960s and 1970s. One must conclude that the development of active and ambitious treatment efforts has little to do with having high numbers of "qualified" psychiatrists or other mental health professionals, an observation that has been substantiated by research in other psychiatric settings (Ellsworth et al., 1979). There is nearly unanimous agreement, locally at least, that open-

ing the unit directorships to nonmedical disciplines has led to a higher quality of program and leadership, and other institutions are now beginning to follow this practice. Indeed, Oak Ridge seems to have attracted and retained some especially talented and determined professionals.

Lack of Local Control

Another emergent theme in our discussion of the history of treatment efforts at Oak Ridge concerns the frequency with which the institution's administration is preempted in its leadership role. This phenomenon is most apparent in a lack of control over admissions and discharges. Decisions about discharges are usually made by autonomous boards of review, while decisions about admissions are made by the courts when they find an accused not guilty or unfit by reason of insanity. Courts rely on the expert testimony of psychiatrists and psychologists, but those who testify about insanity are frequently not the same individuals who treat mentally disordered offenders (see 53 in the Appendix).

Political Control: Treatment Versus Security

For over half of its almost 60-year history, Oak Ridge was run almost entirely by attendants. They organized recreation, dispensed medication (orally and by injection) ran vocational shops, etc. Prior to 1960, aside from attendants, the only other treatment staff were very small numbers of physicians and nurses (fewer than half a dozen at any one time). Through the 1960s and 1970s, small numbers of other university-educated professional staff (social workers, psychologists, recreationists; and in the 1980s, occupational therapists) began to work in Oak Ridge. Unlike attendants who were all men and almost always from the small and ethnically homogeneous local community, these professionals were both male and female and were almost always transplanted urbanites. In time, the increasing numbers of professionals combined with the distinct cultural and professional differences between the two groups began to produce conflict. In reality, there is little doubt that this conflict was caused by the question of which group was to control the institution. The conflict, however, often took the form of struggles in which treatment was pitted against security. That is, the professionals' clinical efforts aimed at the assessment and treatment of patients' problems were often seen by the attendants as efforts to gain control and influence, while attendants' efforts to develop formal and informal security precautions were often seen by the professional staff as efforts to gain similar control and influence. Officially, attendants retained a dual clinical-security role and some ward programs (on the ATU for example) relied on the clinical work of the attendants. However, similar to situations described elsewhere (Ellsworth, 1968), attendants inferred from supervisory and promotional practices that their treatment efforts were undervalued, and they increasingly depended on the development and enforcement of security precautions to define their roles. There were several significant events in this trend toward the "securitization" of the attendants as a group.

The early STU program described above gave attendants almost exclusive responsibility for maintaining static and dynamic security, but a very small

therapeutic role. It was made very explicit that attendants would be supported unconditionally over patients in any disagreement about security (see 51 in the Appendix). Also as mentioned above, the later political crisis resulting in the removal of the STU clinical team contributed to a belief that, if attendants sought control by invoking arguments about security, they would be supported by local and branch superiors. Until the 1970s, attendants' salaries were relatively low, but in 1979 they successfully argued for pay equivalent to provincial jail guards on the grounds that their jobs carried special requirements for maintaining security, and that they were exposed to additional danger by virtue of the patient population. Based entirely on their security role, Oak Ridge attendants now receive substantially higher salaries than equivalently qualified staff elsewhere in the province's psychiatric system. In the 1980s, the attendants successfully argued, on security grounds, that they be present in all group therapy sessions held in Oak Ridge. The practice of having an attendant (not involved in the treatment) sit in on every therapy session continued, almost without exception, for several years. In the late 1980s, at a time when attendants were concerned that static and dynamic security precautions had been allowed to deteriorate, the attendants staged a one-day "lock down" of all patients, preventing them from attending all therapeutic activities. The result of the action was an agreement by administration to form a joint union-management committee to evaluate security and to make recommendations directly to the branch head office. (Although the committee still exists, it now makes its recommendations to the institution's administration.)

The point of this list is to demonstrate that history has conspired to maintain a gulf between attendants and other professionals. It seems that the attendants have consistently met with success in exercising influence and control when they have relied upon their security role. As a result, security concerns often seem to take precedence over therapeutic ones. For example, despite a recommendation from the Hucker Report in 1985, a conjugal visiting program has not yet been implemented. Table knives (and sometimes forks) are not provided for patients' meals. The large number of attendants to patients required by policy means that the swimming pool/gymnasium complex is not fully used, and that a large fenced yard is infrequently used. Many attendants would argue, of course, that such precautions are necessary to ensure the safety of patients, staff, and the public. The point of this discussion, however, is that many unnecessary intrastaff conflicts, have, do, and probably will continue to occur in Oak Ridge because of this mostly unintended gulf between attendants and professional staff. The gulf, and attendants' investment in security that accompanies it, has undoubtedly slowed clinical progress in Oak Ridge. This perception that attendants have resisted clinical progress may be partly responsible for a suggestion that a new maximum security psychiatric institution be built closer to an urban university and that Oak Ridge (and attendant staff) be transferred to the Ministry of Correctional Services. Patient lobby groups intent on closing Oak Ridge make such an option attractive by promoting adverse publicity about the institution. For example, very recently there has been much local media coverage of allegations that many years ago patients were killed by attendants' use of a form of strangle hold designed to produce unconsciousness.

One of the solutions proposed in the Hucker Report to address the issue of

the tension between security and treatment roles of Oak Ridge staff was to abandon the designation of "attendant," designate those ward staff who were not registered nurses as "security aides" and relieve them of all clinical duties. Although this has been done and is reportedly successful at many other security hospitals, attendant, professional, and administrative staff at Oak Ridge have continued to argue in favor of a model in which all staff, whether attendants or professionals, have a dual responsibility for treatment and security. Although experience has shown that such a model has its problems (in ensuring attendants have true clinical responsibilities, for example), we believe that the record of innovative programs combined with an excellent security record attests to the viability, and perhaps even superiority, of such a model.

The Future

After the foregoing section, one might be tempted to conclude that Oak Ridge is a regressive and benighted place. However, as mentioned in earlier sections, despite all the impediments, clinicians in Oak Ridge are responsible for an impressive array of therapeutic services. Indeed, we believe that an objective observer, rating programs for mentally disordered offenders, would rank the programs offered at our institution among the very best in the country and the world despite its old-fashioned prison-like exterior.

The future of Oak Ridge is uncertain, however, the institution may not survive its chequered past. For example, during 1991, head office planners directed an unprecedented public effort in strategic (long-term) planning that involved every unit of every psychiatric facility in Ontario, except for those at Oak Ridge. Recent Supreme Court decisions and recent changes to the Criminal Code of Canada suggest that the requirement that forensic patients be kept under the "least restrictive" conditions possible, and the application of a fixed maximum period of detention or "cap" to the warrants of most patients, may mean that fewer maximum security beds will be required. Also, we conducted an exhaustive survey of forensic patients in Ontario, which shows that the clinical staff most closely associated with forensic patients would assign very few of them to maximum security.

On the other hand, that same survey showed that the preferred placement for most Oak Ridge patients would be a form of high medium-security that does not exist in the Ontario system. Province-wide planning for forensic patients (which is proceeding separately from the planning mentioned above) includes plans for revising the security levels, and it may be that some wards at Oak Ridge will be converted to wards with higher perimeter but lower internal security than has previously been the case. In addition, the same criminal code amendments mentioned above may make the insanity defense (now called not criminally responsible due to mental disorder) more popular. Finally, there is little doubt that some recent spectacular reoffenses perpetrated by forensic patients in medium security facilities will, at least temporarily, introduce considerable caution into disposition decisions. In conclusion, Oak Ridge's future is shrouded in mist and its absence from the system's public planning process suggests that this cloud will persist for some time.

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Appendix: A Selected Chronology of Publications Pertaining to Oak Ridge

1. Lynch, D. O. (1937). Some observations on the criminally insane with special reference to those charged with murder. *The Ontario Journal of Neuro-Psychiatry, 12,* 39–52.
2. McKnight, C. K., Mohr, J. W., & Swadron, B. B. (1962). The mentally ill offender in the Oak Ridge Hospital Unit. *Criminal Law Quarterly, 5,* 248–258.
3. Boyd, B. A. (1963). Correctional staff training. *Canadian Journal of Corrections, 5,* 343–346.
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13. Quinsey, V. L. (1973). Methodological issues in evaluating the effectiveness of aversion therapies for institutionalized child molesters. *Canadian Psychologist, 14,* 350–361.
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18. Quinsey, V. L., & Sarbit, B. (1975). Behavioral changes associated with the introduction of a token economy in a maximum security psychiatric institution. *Canadian Journal of Criminology and Corrections, 17,* 177–182.
19. Quinsey, V. L., Pruesse, M., & Fernley, R. (1975). Oak Ridge patients: Prerelease characteristics and postrelease adjustment. *Journal of Psychiatry and Law, 3,* 63–77.

20. Quinsey, V. L., Pruesse, M., & Fernley, R. (1975). A follow-up of patients found "unfit to stand trial" or "not guilty" because of insanity. *Canadian Psychiatric Association Journal, 20*, 461–467.
21. Quinsey, V. L. (1975). Psychiatric staff conferences of dangerous mentally disordered offenders. *Canadian Journal of Behavioural Science, 7*, 60–69.
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